

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

106786

6796

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Oakland		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - P. O. Gormanria, W. Va.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D O A, at Garrett Co. Mem. Hosp.		d. STREET ADDRESS Red Oak community	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Joseph	Middle Larry	Last Brandt
4. DATE OF DEATH June 12,	Month	Day	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 4, 1904
8. AGE (In years last birthday) 55 yrs.	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS Days	Hours
11. BIRTHPLACE (State or foreign country) Michigan	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James J. Brandt	14. MOTHER'S MAIDEN NAME Nancy Ellen Green		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 234-62-2593	17. INFORMANT Mrs. Joseph Brandt-R.D.Gormanria, W. Va.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>asphyxiation</i>		INTERVAL BETWEEN ONSET AND DEATH 0	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Tracheal Obstruction</i> DUE TO (c) <i>Brachogenic Carcinoma, with generalized metastases</i> DUE TO 1-2 minutes 12-18 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>February</i> , 1959, to <i>June</i> , 1959, that I last saw the deceased alive on <i>May 15, 1959</i> , and that death occurred at <i>7:05A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>5th & Oak Sts., Oakland, Md.</i> DATE SIGNED <i>6/12/1959</i>	
ACTUAL SIGNATURE <i>Richard F. Leighton, M.D.</i>		PHYSICIAN'S NAME (Type) <i>Richard F. Leighton, M. D.</i> Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/14/1959	22c. NAME OF CEMETERY OR CREMATORIUM Gregory Family Cemetery, Red Oak, Garrett Co., Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>He. Leighton</i>	ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE JUN 16 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM STATE GOVERNOR GE HAGUE-SALMONS 18
CERIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with page 3 should be detached for use of the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6797

CERTIFICATE OF DEATH

06787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN lb 7 days		d. STREET ADDRESS SHAW		b. COUNTY MINERAL					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 85 X-3							
3. NAME OF DECEASED (Type or print)		First HERBERT	Middle T.	Last DAWSON	4. DATE OF DEATH JUNE 19 1959	Month JUNE	Day 19	Year 1959			
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/1887	9. AGE (in years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAIL CARRIER				10b. KIND OF BUSINESS OR INDUSTRY Rural Contract				11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME WILLIAM THOMAS DAWSON				14. MOTHER'S MAIDEN NAME ELIZABETH BAILEY				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 236-12-2574		17. INFORMANT LILLIE DAWSON		Address SHAW, WEST VIRGINIA					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } (b) Cerebral Vascular Accident DUE TO (c) Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D. 58 2nd st. Oakland, Md.		(County) 6-19, 1959	(State) OAKLAND, MARYLAND		
21. I certify that I attended the deceased from 6-12, 1959 , to 6-19, 1959 , that I last saw the deceased alive on 6-19, 1959 , and that death occurred at 9:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>										ADDRESS (Street, city or town, state) M.D. 58 2nd st. Oakland, Md.	DATE SIGNED 6-20-59
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR. M.D.		SECOND STREET				OAKLAND, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/22/1959		22c. NAME OF CEMETERY OR CREMATORIUM Ebenezer Church Cemetery, Romney, W. Va.		22d. LOCATION (City, town, or county) Romney, W. Va.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Leggerton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR JUN 23 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur & Kraus</i>					

STATE OF CALIFORNIA

CERTIFICATE OF DEATH

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Death certificate issued by the State of California
Health and Welfare Department, Sacramento, California.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

116788

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		
Gorman		80 yrs.		X Gorman				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First DANIEL	Middle ANDREW	Last EGER	4. DATE OF DEATH	Month JUNE	Day 27	Year 1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	unk/unk/1870	89 yrs.	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Farming		Farm		Virginia		USA		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				
John Daniel Eger				Barbara Yockum				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no		none		Mrs. Ruth Miller		Tacoma Park, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, ACUTE</u> INTERVAL BETWEEN ONSET AND DEATH 420.1 IMMEDIATE								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>James H. Feaster, Jr., M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
DATE SIGNED 6-28-59								
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/30/1959		22c. NAME OF CEMETERY OR CREMATORIUM Pope Cemetery		22d. LOCATION (City, town, or county) Gorman (State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich Oakland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur & Krause</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6799

CERTIFICATE OF DEATH

116789

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 27 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D O A Oakland Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,	
3. NAME OF DECEASED (Type or print) Ray Leibowitz		First Ray	Middle Leibowitz
		Last Feld	4. DATE OF DEATH June 30, 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 29, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland.
13. FATHER'S NAME Joseph Leibowitz		14. MOTHER'S MAIDEN NAME Lena Glass	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Irvin Feld
		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Acute Myocardial Insufficiency INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic Cardio Vascular Disease 20 years. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 1957 to June 11:50 P.M. , 1959, that I last saw the deceased alive on June 15, 1959 , and that death occurred at 779 Oak Street, Oakland, Md. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton		ADDRESS (Street, city or town, state) 779 Oak Street, Oakland, Md. DATE SIGNED July 6, 1959	
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7/3/1959	
22c. NAME OF CEMETERY OR CREMATORIUM Mogen Abraham Cemetery		22d. LOCATION (City, town, or county) Rosedale, Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE JUL 6 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6800

CERTIFICATE OF DEATH

06790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland Rt# 2		c. LENGTH OF STAY IN 1b unk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland Rt# 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Emma	Middle Christine	Last Frazee	4. DATE OF DEATH	Month 6	Day 29	Year 1959
5. SEX Femal	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/25/1893	9. AGE (In years last birthday) yrs. 66	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Accident, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Margroff				14. MOTHER'S MAIDEN NAME Hanna Fredick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Carl Frazee		Address Oakland Rt# 2, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO <i>Aneurism, Ruptured</i> INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Arteriosclerosis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Nat white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-3-</u> , 19 <u>58</u> , to <u>6-2-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/2/59</u> , 19 <u>59</u> , and that death occurred at <u>Oakland</u> , 19 <u>59</u> M. from the causes and on the date stated above. ACTUAL SIGNATURE <u>Andrew S. Mance</u> M.D. ADDRESS (Street, city or town, state) <u>Oakland, Md.</u> DATE SIGNED <u>30 June 1959</u>							
PHYSICIAN'S NAME (Type) A.E.MANCE, M.D.		OAKLAND, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>7/2/1959</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Oakland Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Oakland</u> <u>Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gerald N. Minnich</u> <u>Oakland, Maryland</u>				24a. REC'D BY REGISTRAR DATE JUL 6 '59		24b. REGISTRAR'S SIGNATURE <u>Charles S. Krause</u>	

13

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06791			
CERTIFICATE OF DEATH										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McHenry, Md. c. LENGTH OF STAY IN 1b 15 Months d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X McHenry, Md. d. STREET ADDRESS /								
3. NAME OF DECEASED (Type or print) First JOHN Middle KLOTZ					4. DATE OF DEATH June 9 1959					Month	Day	Year	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Apr. 14, 1879					9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer retired			10b. KIND OF BUSINESS OR INDUSTRY own farm			11. BIRTHPLACE (State or foreign country) Bittinger, Garrett Co., Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Christian Klotz					14. MOTHER'S MAIDEN NAME Mary Pope								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 216-38-1942			17. INFORMANT Raymond Klotz, McHenry, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					Cerebral hemorrhage					INTERVAL BETWEEN ONSET AND DEATH 1 day.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					Hypertension					10 years			
DUE TO (c)					Arteriosclerosis					10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) —		(County) —	(State) —
21. I certify that I attended the deceased from May 8, 1959 , to June 9, 1959 , that I last saw the deceased alive on June 8, 1959 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) 349 Main St. Meyersdale, Pa.			
ACTUAL SIGNATURE C. W. STOTLER, M.D.										DATE SIGNED 6/10/59			
PHYSICIAN'S NAME (Type) C. W. STOTLER, M.D.					349 MAIN ST. MEYERSDALE, PA.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/59		22c. NAME OF CEMETERY OR CREMATORIAL Accident			22d. LOCATION (City, town, or county) Garrett Co., Md.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE John J. Newman					ADDRESS Grantsville, Md.					24a. REC'D BY REGISTRAR Arthur S. Krause		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	
										DATE JUN 16 '59			

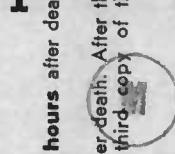
INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS AISC 1-55 10M

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6802

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06792

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH GARRETT COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN KITZMILLER			2. USUAL RESIDENCE (HOME) OF DECEASED MARYLAND STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KITZMILLER		
HOSPITAL OR INSTITUTION OR STREET ADDRESS MAIN STREET			STREET ADDRESS (If rural give location) MAIN STREET		
3. NAME OF DECEASED (First) MAUDE (Middle) ELIZABETH (Last) KNOTTS (Type or Print)			4. DATE OF DEATH JUNE 17 1959		
5. SEX FEMALE	6. COLOR OR WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 8, 1882	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME WORK			10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
13. FATHER'S NAME JAMES EVERETT			14. MOTHER'S MAIDEN NAME ALICE DULEY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No.) No			16. SOCIAL SECURITY NO. 216-09-2792B	17. INFORMANT & ADDRESS Elza Knotts, Kitzmiller, Md.	
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <i>Acute Myocardial Dapping</i> ANTECEDENT CAUSE(S) DUE TO <i>Cerebral hemorrhage with rt</i> DISEASES OR CONDITIONS, IF ANY, (B) <i>sided paralysis</i> GIVING RISE TO THE ABOVE CAUSE DUE TO <i>Fracture of rt hip</i> STATING UNDERLYING CAUSE LAST. (C)					
INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>5 yrs</i> <i>8 yrs.</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb 17, 1951</i>, to <i>June 17, 1959</i>, that I last saw the deceased alive on <i>June 17, 1959</i>, and that death occurred about <i>5 P.M.</i>, from the causes and on the date stated above.					
SIGNATURE <i>Ralph Calandella</i> ADDRESS (Street, city, town, state) <i>Bethany Rd</i> DATE SIGNED <i>June 18-59</i> LOCATION (City, town, or county) <i>Elk Garden, W.Va.</i> (State) <i>W.Va.</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/20/59		NAME OF CEMETERY OR CREMATORIUM I.O.O.F. Cemetery	
24. REC'D BY REGISTRAR DATE JUN 22 '59		REGISTRAR'S SIGNATURE Arthur S. Tamm		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Legerton Oakland, Md.	

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12. 11. 1918

الآن في المدارس (فوج) 12. 11. 1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6803 CERTIFICATE OF DEATH

Reg. Dist. No. **06793**

1. PLACE OF DEATH a. COUNTY Garrett		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland		c. LENGTH OF STAY IN 1b 38 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland.		b. COUNTY Garrett					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION near Red House		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland		f. STREET ADDRESS 9 Mi. S. Oakland		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Floyd		First	Middle	Last	4. DATE OF DEATH Lee June 29, 1959	Month	Day	Year					
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1875		9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Perry Lee		14. MOTHER'S MAIDEN NAME Sarah Moreland											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-38-6196		17. INFORMANT Earl Lee		Address Oakland, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis - Nutostatic INTERVAL BETWEEN ONSET AND DEATH 8 weeks													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Carcinoma of Stomach 8 months											
		DUE TO (c) arterio Sclerosis 6 years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 2-28- , 19 58 to 6-29 , 19 59 , that I last saw the deceased alive on 6-11 , 19 59 , and that death occurred at M , from the causes and on the date stated above.													
ACTUAL SIGNATURE Andrew E. Mance		ADDRESS (Street, city or town, state) Oakland, Md.										DATE SIGNED 30 June 1959	
PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/1959		22c. NAME OF CEMETERY OR CREMATORIUM Red House Church Cem.		22d. LOCATION (City, town, or county) Garrett Co., Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE H. L. Reighton		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR C. E. Thomas		24b. REGISTRAR'S SIGNATURE C. E. Thomas				DATE JUL 6 '59			

STATE OF SOUTH DAKOTA
CITY OF SIESTON

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Form PM3. Page 5 should be used as a burial-trust permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6804 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

116794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland.		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Star Route, Oakland,				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital				d. STREET ADDRESS 1/6 Mi. N. Oakland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First John	Middle Michael	Last Long	4. DATE OF DEATH Month June	Day 18,	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sept. 12, 1883	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 0	Days 0	IF UNDER 24 HRS. Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Adam H. Long		14. MOTHER'S MAIDEN NAME Anna Catherine Bloss						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-12-5966		17. INFORMANT Lonnie Long Star Route, Oakland, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion, right					Sudden	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							-----	
(b) DUE TO Coronary osteal sclerosis							-----	
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Deer Park	(County) Md.	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <i>6.19.59</i>	
EXAMINER'S NAME (Type) James H. Feaster Jr., M. D.								
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/1959		22c. NAME OF CEMETERY OR CREMATORIUM Deer Park Cemetery		22d. LOCATION (City, town, or county) Deer Park, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. H. Leighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE JUN 22 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haas</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

116795

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6805 Item 2 Film G244 7-7-59 et
CERTIFICATE OF DEATH

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY <i>Sarrett</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Penna. Maryland</i> b. COUNTY <i>Sarrett?</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN lb <i>7 mos</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> Hyndman 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Carpets Nursing Home</i>		d. STREET ADDRESS <i>1666 E. 1st Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>WILLIAM</i>	Middle <i></i>	Last <i>Lowery</i>	4. DATE OF DEATH <i>JUNE 25</i>	Month Day Year <i>1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/17/1882</i>	9. AGE (In years last birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Railroad employee</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>		11. BIRTHPLACE (State or foreign country) <i>Cooks Mills, Pa.</i>	
13. FATHER'S NAME <i>Fillmore Lowery</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Albright</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mr. Charles Sisler, Hyndman, Pa.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cholera</i> DUE TO <i>1465X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____					
INTERVAL BETWEEN ONSET AND DEATH <i>12 days</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Venereal disease</i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>July 15 1959</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <i></i>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	
20f. (City or town) <i></i>		(County) <i></i>		(State) <i></i>	
21. I certify that I attended the deceased from <i>July 15, 1959</i> to <i>July 25, 1959</i> , that I last saw the deceased alive on <i>July 25, 1959</i> , and that death occurred at <i>2:15 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>25 Almoe St. OAKLAND - MD.</i>					
DATE SIGNED <i>6/20/59</i>					
ACTUAL SIGNATURE <i>E. Baumgartner</i>					
PHYSICIAN'S NAME (Type) <i>E. Baumgartner</i>					
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 28, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Cooks Mills Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Hyndman, Pa. RD#1</i>		(State) <i></i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harvey J. Zeigler</i>					
ADDRESS <i>Hyndman, Pa.</i>					
24a. REC'D BY REGISTRAR DATE <i>JUN 30 '59</i>					
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 Film G244 7-20-59 et
6806 CERTIFICATE OF DEATH

ITEM 2 FILM G244 7-20-59 ET

06796

1. PLACE OF DEATH o. COUNTY GARRETT			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	c. LENGTH OF STAY IN 1b 4 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Swanton			b. COUNTY GARRETT			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL			d. STREET ADDRESS RFD					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) LILLIE MAE MASON		First LILLIE	Middle MAE	Last MASON	4. DATE OF DEATH JUNE 27 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH SEPT. 6, 1878	9. AGE (In years lost birthday) yrs. 80	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME RUCKNER FAIRFAX MASON			14. MOTHER'S MAIDEN NAME CLARA BELLE WELCH					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO. - - -		17. INFORMANT CHARLES C. MASON, MT. LAKE PARK, MD.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO clerical cirrhosis			INTERVAL BETWEEN ONSET AND DEATH 6 mos					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 0 Asthma DUE TO (c)			10955					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) oakland, Md.		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from JUNE 22, 1959 to JUNE 27, 1959 , that I last saw the deceased alive on JUNE 26, 1959 , and that death occurred at 4:20 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE Andrew E. Mance M.D.							ADDRESS (Street, city or town, state) Oakland, Md.	
PHYSICIAN'S NAME (Type) DR. ANDREW E. MANCE, M.D.							DATE SIGNED 27 June 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/1959		22c. NAME OF CEMETERY OR CREMATORIUM North Glade Cemetery		22d. LOCATION (City, town, or county) near Swanton, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton			ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR JUL 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

DEPARTMENT OF HUMAN RESOURCES
CERTIFICATE OF DEATH

302

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6807 CERTIFICATE OF DEATH

116797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park,		c. LENGTH OF STAY IN 1b 60 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4 Mi. N. Deer Park, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Andrew	Middle Thomas	Last Miller
4. DATE OF DEATH	Month June	Day 13,	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1890
9. AGE (In years last birthday) 68	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11. KIND OF BUSINESS OR INDUSTRY Wood Working	12. BIRTHPLACE (State or foreign country) Maryland.
13. CITIZEN OF WHAT COUNTRY? U.S.A.	14. MOTHER'S MAIDEN NAME Mary Ann Johnson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 218-12-5125	17. INFORMANT Mrs. Hazel Glass	Address R.D. Deer Park, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 527.1			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Emphysema - Chronic DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 6 hours			
10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 58 , to June 13, 1959 , that I last saw the deceased alive on June 12 , 19 59 , and that death occurred at 8:30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Herbert H. Leighton</i>		ADDRESS (Street, city or town, state) 77 Oak Street, Oakland, Md.	
DATE SIGNED 14 Jun 59			
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.		22a. BURIAL, CREMATION OR REMOVAL (specify) Burial	
22b. DATE THEREOF 6/15/1959		22c. NAME OF CEMETERY OR CREMATORIUM Thayerville Cemetery	
22d. LOCATION (City, town, or county) Garrett Co., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>HC Leighton</i>		24a. REC'D BY REGISTRAR DATE JUN 16 '59	
ADDRESS Oakland, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6808

CERTIFICATE OF DEATH

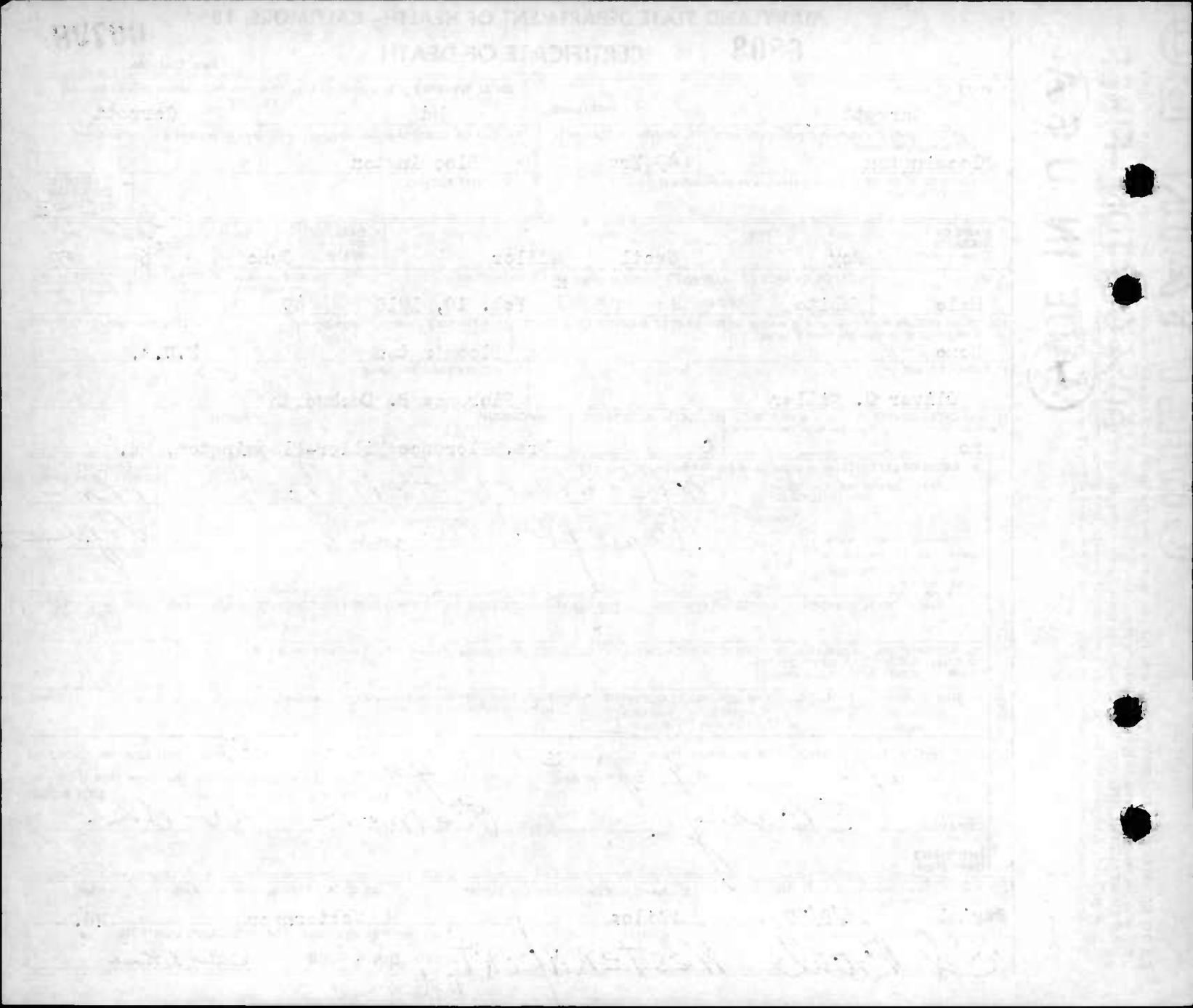
106798

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomington		c. LENGTH OF STAY IN 1b 49 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bloomington	
3. NAME OF DECEASED (Type or print) Roy		First Cecil	Middle Miller
4. DATE OF DEATH June 6 1959	Month June	Day 6	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1910
9. AGE (In years last birthday) 49 yrs.	10. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Bloomington	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Oliver C. Miller		14. MOTHER'S MAIDEN NAME Florence R. Duckworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 0	
17. INFORMANT Mrs. Florence Miller-Bloomington, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr - life <i>Myocardial failure</i> <i>Epileptic seizure</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Piedmont	
21. I certify that I attended the deceased from June 1, 1959 to June 6, 1959 that I last saw the deceased alive on 6/6/59 , and that death occurred at 40 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE P. E. Berry		ADDRESS (Street, city or town, state) Piedmont	
PHYSICIAN'S NAME (Type) Arthur S. Thomas		DATE SIGNED W. Va.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/59	
22c. NAME OF CEMETERY OR CREMATORIUM Philos		22d. LOCATION (City, town, or county) (State) Westernport	
23. FUNERAL DIRECTOR'S SIGNATURE S. J. Boul		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR JUN 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6809

CERTIFICATE OF DEATH

06799

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VINDEX		c. LENGTH OF STAY IN 1b 1 Month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WEST VINDEX		e. STREET ADDRESS West Vindex	
f. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JAMES	Middle WILLIAM	Last NELSON
4. DATE OF DEATH	Month JUNE	Day 22	Year 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 3, 1872
9. AGE (In years (at time of death) 87) yrs.	10. USUAL OCCUPATION (Give kind of work done during working life, even if retired) MINER	11. KIND OF BUSINESS OR INDUSTRY COAL MINES	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME PHILIP	14. MOTHER'S MAIDEN NAME NANCY	<i>Not Known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Mrs. Tenna Paugh, R#1, Swanton, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Coronary Heart Disease		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jan 1950, to June 22, 1959
20f. (City or town) Kitzmiller, Md.	(County) Garrett Co., Md.	(State) Md.	
21. I certify that I attended the deceased from Jan 1950, to June 22, 1959 , that I last saw the deceased alive on June 22, 1959 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph Calandrella		ADDRESS (Street, city or town, state) Kitzmiller, Md.	
DATE SIGNED 6/23/59			
PHYSICIAN'S NAME (Type) Dr. Ralph Calandrella, M.D.			
22a. BURIAL, CREMATION, BURIAL (Specify) Burial	22b. DATE THEREOF 6/25/59	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Zion Cemetery	22d. LOCATION (City, town, or county) R#1, Swanton, Garrett Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Keightley	ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE JUN 29 '59	24b. REGISTRAR'S SIGNATURE Arlyn & Krause

CERTIFICATE OF DEATH

Date:

WILLIAM FREDERICK
BROWN (deceased)

To stand or not to stand
To be or not to be.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial; cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6810 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 06800
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Garrett					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton,		c. LENGTH OF STAY IN lb 63 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Swanton					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1 Mile west of Swanton					d. STREET ADDRESS 1 Mile west, on farm					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First William	Middle Lewis	Last Otto	4. DATE OF DEATH	Month June	Day 17,	Year 19 59		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	June 6, 1896	9. AGE (in years from birthday) 65 yrs.	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Farmer			10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William H. Otto					14. MOTHER'S MAIDEN NAME Mary Elizabeth O'Brien					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-16-5864		17. INFORMANT Miss Nina Otto			Address Swanton, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Myocardial Infarction, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH Minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial infarction March 1958										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>								
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . ACTUAL SIGNATURE James H. Feaster, Jr., M. D.										DATE SIGNED 6-17-59
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/1959	22c. NAME OF CEMETERY OR CREMATORIUM North Gladd Cemetery			22d. LOCATION (City, town, or county) near Swanton, Md.				(State)
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR JUN 18 '59			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6811 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06801

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb ---		a. STATE Maryland		b. COUNTY Garrett	
Rural Kitzmiller				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Vindex	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Route 42, 4 Mi. N. Kitzmiller		d. STREET ADDRESS / ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Ira	Middle Everett	Last Paugh	4. DATE OF DEATH	Month June	Day 27, 19 59
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE [In years last birthday] 28 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 15, 1930			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Laborer			General		Maryland.		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Ira Hobart Paugh				Ethel May Paugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
		215-26-9783		Ethel May Paugh		Vindex, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED SKULL INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE							
823 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CRUSHED CHEST IMMEDIATE							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cause of Death. Auto accident, car ran off of road and turned over killing driver.							
20c. TIME OF INJURY Month, Day, Year 10:40 a.m. 6-27 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Rural Vindex, Garrett, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-27-59	
EXAMINER'S NAME (Type) James H. Feaster Jr. M. D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/1959		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) near Swanton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Leighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR JUL 1 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be retained by the hospital or attending physician. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116802

6812

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS BAYARD 85 x 3	
3. NAME OF DECEASED First Artenchie Middle Long Last PENNINGTON		4. DATE OF DEATH Month JUNE Day 12 Year 1959	
5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> NOV. 1, 1884		9. AGE (In years lost birthday) 74 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL LONG		14. MOTHER'S MAIDEN NAME Not known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----- 17. INFORMANT BLAKE PENNINGTON Address BAYARD, W.VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion, Acute INTERVAL BETWEEN ONSET AND DEATH Minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic Cardio Vascular Disease 20 years (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I ① Lobar Pneumonia ② Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February, 1957 to June 12, 1959 , that I last saw the deceased alive on June 12, 1959 , and that death occurred at 5:55 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Robert H. Leighton, M.D. ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. DATE SIGNED 13 Jan 59			
PHYSICIAN'S NAME (Type) ROBERT H. LEIGHTON, M.D.		77 OAK STREET OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 6/15/1959		22c. NAME OF CEMETERY OR CREMATORIUM Lanesville Cemetery 22d. LOCATION (City, town, or county) (State) Tucker County, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Leighton		ADDRESS Oakland, Md. 24a. REC'D BY REGISTRAR JUN 16 1959 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6813 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

116803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Swanton		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 Mi W. Swanton				d. STREET ADDRESS 418 Hammond					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First Marion	Middle Francis	Last Reeves	4. DATE OF DEATH	Month Jane	Day 6	Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1897	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Manager			10b. KIND OF BUSINESS OR INDUSTRY C & A Gas Co.	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Richard Reeves			14. MOTHER'S MAIDEN NAME Mary Frye						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-05-8162		17. INFORMANT	Address Mrs Marion Reeves— Westernport, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH Inver.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> <u>850 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently fell in the water while refueling his motor. He was fishing alone at the time.							
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- p. m. 6/ - 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Deep Creek Lake		(County) Garrett	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>James H. Feaster, Jr. M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-7-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/59		22c. NAME OF CEMETERY OR CREMATORIUM Philos		22d. LOCATION (City, town, or county) Westernport		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E.S. Boal		ADDRESS El. Boal, Westernport, Md.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		DATE JUN 9 '59	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6814

CERTIFICATE OF DEATH

06804

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,			c. LENGTH OF STAY IN 1b 3½ yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			d. STREET ADDRESS Paca Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Myrtle	Middle Mongold	Last Simmons	4. DATE OF DEATH June 23,	Month Year 1959	Day	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1885			9. AGE (In years at birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse and			10b. KIND OF BUSINESS OR INDUSTRY House work	11. BIRTHPLACE (State or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Jacob Mongold			14. MOTHER'S MAIDEN NAME Martha Pratt								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. ---			17. INFORMANT Mrs. Vincent Wigger			Address 915 Atlantic Ave. Lavale, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition</i>			DUE TO <i>501X</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Branchitis</i>			DUE TO <i>Uremia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Anterosclerosis</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED 19 While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> p. m.			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Jau 1, 1957</i> to <i>June 22, 1959</i> , that I last saw the deceased alive on <i>June 22, 1959</i> , and that death occurred at <i>8:55 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James H. Feaster Jr.</i> M.D. 58 2nd St. Oakland, Md. 20521-25-59			ADDRESS (Street, city or town, state)			DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6/26/1959			22c. NAME OF CEMETERY OR CREMATORIUM I.O.O.F. Cemetery			22d. LOCATION (City, town, or county) Elk Garden, W. Va. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.C. Leighton</i>			ADDRESS Oakland, Md.			24a. REC'D BY REGISTRAR DATE JUN 29 '59			24b. REGISTRAR'S SIGNATURE <i>Arthur & Anna</i>		

WILLIAMSON STATE BANK—PAGE 18

CERTIFICATE OF DEATH

NO. 100-1000

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6815 CERTIFICATE OF DEATH

06805

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Sarrett</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oakland Md</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland 23d. 01-02-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Weeks Nursing Home</i>		d. STREET ADDRESS <i>11 Heavenly Terrace</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Carl</i>	Middle <i>SPEELMAN</i>	Last Month Day Year 6 20 19 59
4. DATE OF DEATH			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 14, 1876</i>
9. AGE (In years last birthday) <i>82 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Sheriff</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	11. BIRTHPLACE (State or foreign country) <i>Hazen Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>N. S. A.</i>			
13. FATHER'S NAME <i>George Speelman</i>	14. MOTHER'S MAIDEN NAME <i>Phoenix Leesme</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes/no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mrs Anna Molinari Cumb. Md.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>723.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO Arteriosclerosis Osteo-arthritis			INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-20-59</i> , 19 <i> </i> , to <i>6-20-59</i> , 19 <i> </i> , that I last saw the deceased alive on <i>6-17-59</i> , 19 <i> </i> , and that death occurred at <i>11:15A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>58 2nd. St., OAKLAND, MD.</i>			
ACTUAL SIGNATURE <i>JAMES H. FEASTER, JR., M.D.</i>	DATE SIGNED <i>6-20-59</i>		
PHYSICIAN'S NAME (Type) <i>JAMES H. FEASTER, JR., M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/23/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Funeral Home. P. B.</i>	22d. LOCATION (City, town, or county) <i>Cumberland. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc.</i>	ADDRESS <i>Cumb. Md.</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 25 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 24 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland ✓			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CUPPETT NURSING HOME				d. STREET ADDRESS 13 Decatur St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Philip		First Timbrook Middle Last 		4. DATE OF DEATH Month 6 Day 9 Year 19 59			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> May 17, 1873		9. AGE (In years from birthday) 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. farmer			10b. KIND OF BUSINESS OR INDUSTRY Own farm			11. BIRTHPLACE (State or foreign country) W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Taylor Timbrook		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA INTERVAL BETWEEN ONSET AND DEATH weeks 442 X							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) MALNUTRITION weeks							
DUE TO (c) ARTERIOSCLEROTIC CARDIO-RENAL DISEASE years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Fester Jr.</i>		DATE SIGNED 6-9-59					
EXAMINER'S NAME (Type) JAMES H. FESTER, JR., M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 12, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Romney, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE JUN 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **116807**

1. PLACE OF DEATH a. COUNTY GARRET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		b. COUNTY MONONGALIA	
c. LENGTH OF STAY IN 1b 8 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MORGANTOWN (RURAL) 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home		d. STREET ADDRESS Rt 2 Box 412	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROSE		First ROSE	Middle Florence
4. DATE OF DEATH Month JUNE Day 6 Year 1959		Wiseman	Lost XXXXXX
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 20, 1880
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Anthony Smith		14. MOTHER'S MAIDEN NAME Margaret Morgan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	17. INFORMANT Brooks Wisman RD Morgantown, W. Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X		UREMIA	INTERVAL BETWEEN ONSET AND DEATH 3 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost: (b)		ARTERIOSCLEROTIC CARDIO. RENAL DISEASE	YEARS
(c)		HYPERTENSION	YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) OLD CEREBRAL VASCULAR ACCIDENT		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 58 21st. St., OAKLAND, MARYLAND		(County) 6-6-59	(State)
21. I certify that I attended the deceased from 6-3-57 , 19_____, to 6-5-59 , 19_____, that I last saw the deceased alive on 6-3-59 , 19_____, and that death occurred at 8:50A M , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>James H. Feaster</i>		DATE SIGNED 6-6-59	
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D.		58 21st. St., OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/1959	22c. NAME OF CEMETERY OR CREMATORIUM Beverly Hills Memorial Cemetery
22d. LOCATION (City, town, or county) Morgantown, W. Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>He Leighton - Oakland</i>		ADDRESS Cemetery	24a. REC'D BY REGISTRAR DATE JUN 8 '59
		Cemetery	24b. REGISTRAR'S SIGNATURE <i>Charles S. Knobell</i>

